DEVELOPMENT OF COMMUNITY-BASED IEC STRATEGY FOR BUNGOMA DISTRICT INITIATIVE

MALARIA INTERVENTIONS

Technical Meeting 6-7 July 1998
Strategy Development Workshop 8-10 July 1998

Webuye, Kenya

Nicholas Dondi
Nancy McCharen

BASICS Technical Directive Number 000 NI 01 040/000 KN 01 014/017 ER 01 051
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ACRONYMS

AIMI	Africa Integrated Malaria Initiative
AMREF	African Medical Research and Education Foundation
ANC	Antenatal clinic
BASICS/HQ	Basic Support for Institutionalizing Child Survival/Headquarters
BDI	Bungoma District Initiative
CA	Contracting agency
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
CQ	Chloroquine
CT	Caretaker
DHMT	District health management team
GOK	Government of Kenya
HF	Health facility
HW	Health worker
IEC	Information, education, and communication
IMCI	Integrated management of childhood illness
IPC	Interpersonal communication
ITM	Insecticide-treated materials (bednets, curtains)
JHU/PCS	Johns Hopkins University/Population Communication Services
KAP	Knowledge, attitude, and practice
MCU	Malaria Control Unit
MOH	Ministry of Health
SP	Sulfadoxine + Pyrimethamine (Fansidar)
TA	Technical assistance
TBA	Traditional birth attendant
TT	Tetanus toxoid immunization
VIPP	Visualization in participatory planning
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development

BACKGROUND

Activities of the BDI project started in Bungoma in 1996, although the project was not formally launched until March 1998 The activities carried out by the project have included a household survey, qualitative community research, formative research on caretaker behaviors, and an IEC assessment These studies formed the basis of the IEC strategy development

WORKSHOP PLANNING

Subsequent to a planning meeting at BASICS/HQ and two conference calls uniting Kenya, Atlanta, and Washington, Nancy McCharen and Nicholas Dondi travelled to Kenya to work with local colleagues to plan and carry out a technical meeting in preparation for a workshop in Bungoma for the drafting of a community-based IEC strategy A schedule of the consultants' activities is included in Appendix A

WORKSHOP DESIGN

The workshop was divided in two parts the technical meeting (two days) and the community-based strategy development workshop The purpose of the technical meeting was to analyse available data, determine key problem behaviours to address, and reach consensus on the technical recommendations to guide IEC activities Starting from the base laid by the technical meeting, the second workshop was expected to develop a strategy for the promotion of practices to improve malaria treatment and prevention in the community

WORKSHOP PARTICIPANTS

The technical meeting was attended by 23 participants from the Bungoma DHMT, USAID, BASICS, AMREF, the Malaria Control Unit of the MOH headquarters, Primary Health Care and the Health Education Division, and JHU/PCS (See Appendix B) In the strategy development workshop, they were joined by representatives of Bungoma based NGOs, religious organizations, and major employers, to make a group of 38 participants (See Appendix C)

WORKSHOP OBJECTIVES AND TIMETABLE

The purpose of the technical meeting was to discuss and reach consensus on technical recommendations to be used in the development of the community-based strategy These recommendations were made after careful review of the national malaria policy, the BDI project, the findings from research done to date in Bungoma District, and a discussion of the key elements of a strategy (See Appendix D, Technical Meeting Proposed Objectives) Participants

were asked for their expectations, and most coincided with the objectives foreseen by the organizers Some participants would have liked more information on budgets, but it was agreed that this topic was outside the scope of the workshop and the facilitators' competence Most expectations focussed directly on learning about the national guidelines and the development of an IEC strategy

The aim of the community-based strategy development workshop which followed was to bring community people together with technical people to draft a community-based IEC strategy for malaria control, based on the problems identified in various pieces of research When asked for their expectations, many participants wanted up-to-date, specific information about malaria Hence, a fourth objective of providing this information was added, and a session incorporated into the program This workshop also created relationships between the DHMT and the community, which will assist in the implementation of the program (See Appendix E, Strategy Development Workshop Proposed Objectives)

Timetables are included in Appendix F

WORKSHOP PROCESS

The methodology used in both parts of the workshop was almost entirely participatory Presentations were made to provide background information on the BDI project, the national policy, and the research Card collection (modified VIPP), work in pairs and small groups, and plenary question and answer discussions were all used The trainers developed facilitation notes to assure a varied and participatory approach to the deliberations Materials covered were typed and made available for use in subsequent discussions (See Appendix G, Facilitation Notes)

EVALUATION

Evaluation was ongoing and included several methods 1) a daily "mood metre," 2) a feedback committee of three participants each day, 3) yellow card warnings that could be used when comments were off subject, boring, or taking too long, 4) a written evaluation at the end of the technical meeting (Tuesday), and 5) a final evaluation after the community-based strategy development workshop (Friday) As would be expected, the mood metre registered some uncertainty in the early part of the week, but by Thursday and Friday, all dots were marked in the block with the happy face The feedback committee polled participants daily Comments tended to relate to logistical issues such as 1) the level of out-of-pocket allowance, 2) the smell of the hair saloon next door, and 3) the amount of *mandazi* at tea time However, good participation, good facilitation, and appreciation of the opportunity to bring issues out into the open were also noted in daily feedbacks

The written evaluations document the attainment of objectives of the two sessions In the evaluation of the technical meeting, three of the four objectives were rated 4 or higher on a scale of 1-5, only the objective on review of research and identification of KAP gaps was rated slightly lower, an average of 3 8 Usefulness of the workshop was rated at 4 6 Comments on the workshop highlighted the participatory methodology, the appreciation of the workshop as a forum to bring together a variety of viewpoints, and the consensus reached on certain specific technical recommendations, which initially were quite contentious "By the time we reached technical input, there was broad consensus already built " (See Appendix H, Technical Meeting Final Evaluation)

The final evaluation of the workshop showed that all objectives had been reached, with an average score of 4 or better Usefulness of the workshop for strategy development averaged 4 7 (the highest of all indicators rated), and participants felt their expectations were met (score 4 0) Comments affirmed the approach "A very important participatory method of involving all stakeholders in planning" and identified potential difficulties such as level of community participation, funding and resource issues, and commitment of the various partners When asked what contribution their organization could make, participants noted their ability to disseminate information, develop IEC materials, and provide TA, supervision, already-trained community workers, and funding (See Appendix I, Community-Based Strategy Development Workshop Final Evaluation)

WORKSHOP OUTCOMES

- Draft community-based IEC strategy (included in Appendix J) The draft needs to be reviewed and completed by the DHMT The strategy includes identification of issues that need attention, and recommendations for addressing outstanding issues, finalizing, and ensuring smooth implementation of IEC activities The strategy identifies problem behaviours to address, behaviours to promote, IEC objectives, target groups, channels of communication, partners, strategies, and activities The DHMT should now take early steps to finalise the draft by determining the IEC material to develop, messages to disseminate, implementation time frame, and progress indicators to facilitate monitoring and evaluation

- Technical recommendations to guide IEC activities (see Draft Community-based IEC Strategy in Appendix J, page 9) The consensus on technical recommendations reached during the workshop should facilitate development of IEC messages and programs

ISSUES AND RECOMMENDATIONS

- Although research has not been completed in all areas, a good foundation is available for caretaker and health worker treatment behaviors **Materials development in anticipation**

of program implementation should be started as soon as possible These should be specific materials for specific target audiences Some examples include church groups materials that could relate to Biblical themes and beliefs dealing with the body which support the best treatment (and eventually preventive measures) of malaria, or factory programs materials might build on the idea that a worker who knows his wife and child are protected has peace of mind and is more productive, or materials for shopkeepers might address the theme that effective treatment brings more customers

- The draft IEC strategy identifies areas of activity that need to be addressed **As it is not clear who will manage or fund some of the activities, there is need for a meeting of CAs to determine roles and responsibilities in the implementation of activities** The meeting should also advise on the role of new partners such as JHU/PCS

- Although critical to community management of malaria, it was not possible to discuss community participation exhaustively during the workshop The main type of community participation identified was the training of volunteers, such as CHW However, because of high attrition rates and inadequate supervision, these programs have had limited success Variations of these models or other formulas for community participation that would train a broader range of people in a village (rather than 1 or 2 volunteers) or that would involve a rotation of volunteers in specific tasks in a limited time period (rather than 1 or 2 volunteers performing all of the tasks over a period of years) might be more appropriate for BDI **These ideas need to be explored so that BDI can incorporate an effective approach to community participation into its program implementation A follow-up workshop involving more community members to come up with a workable approach would help BDI find an effective approach** Simply using community members to pass on messages and information will not have the desired result

NEXT STEPS

- Policy issues were identified for follow up at the national level 1) determination of suitable generics, 2) launching of the new guidelines, 3) supply of SP in kits, 4) SP packaging and pricing, and 5) addressing of misleading adverts These issues are to be pursued by Millie Busolo, Victor Masbayi, and Mary Ettling

- Finalization of IEC strategy and planning for implementation Dondi to meet with DHMT and AMREF with a draft strategy and consultants' recommendations during the week of July 27

- Meeting of CAs to determine roles and responsibilities in the implementation of activities

- Initiation of materials development process, contingent on decisions made in CA meeting

- Follow-up coordination meetings with Dondi and key partners, subsequent to the finalization of the IEC strategy and implementation planning,

- Regarding community participation 1) additional discussions with the communities involved, 2) approach with problem solving, using menus of problems identified in the IEC strategy development workshop, and 3) fieldwork and workshop

APPENDIXES

APPENDIX A

SCHEDULE OF CONSULTANTS' ACTIVITIES

APPENDIX A
SCHEDULE OF CONSULTANTS' ACTIVITIES

TUESDAY JUNE 9, 1998
9 00 - 14 00 Planning meeting in Washington, DC with CDC, BASICS, USAID

WEDNESDAY JUNE 10, 1998 AND WEDNESDAY JUNE 24, 1998
9 30 Conference calls between AMREF, USAID/Kenya, DHMT, BASICS

SUNDAY 14 JUNE 1998
Nicholas Dondi returns to Kenya

WEDNESDAY JULY 1, 1998
Nancy McCharen arrives in Nairobi

THURSDAY JULY 2, 1998
11 00 Meeting with Victor Masbayi, USAID
16 00 Meeting with Hezron Ngugi, AMREF

FRIDAY JULY 3, 1998
Travel to Webuye, Bungoma District

SATURDAY JULY 4, 1998
Workshop preparations

SUNDAY JULY 5, 1998
Participants arrive, meeting with Mr Ngugi

MONDAY JULY 6 - FRIDAY JULY 10, 1998
Technical meeting and IEC Strategy Development Workshop

SATURDAY JULY 11, 1998
Drafting of IEC Strategy and trip report

MONDAY JULY 13, 1998
Debriefing with Dr Odongo, Medical Officer Bungoma, meeting with Mr Ngugi, AMREF
Travel to Nairobi

TUESDAY JULY 14, 1998
Work on draft of IEC Strategy and Trip Report

WEDNESDAY JULY 15, 1998

15 00 Debriefing at USAID/Kenya with Victor Masbayi, USAID Program Manager, Neen Alrutz, Technical Advisor for AIDS and Child Survival, OPH and Acting Mission Director, Hanna Dagnachery, Office of Population and Health, Karingari Kiragu, JHU/PCS, Dan Odallo, JHU/PCS, Michelle Folson, REDSO/OPH

22 15 McCharen departs for Washington, DC

APPENDIX B

PARTICIPANT LIST
BDI TECHNICAL MEETING
6-7 JULY 1998
WEBUYE, KENYA

APPENDIX B
PARTICIPANT LIST
BDI TECHNICAL MEETING
6-7 JULY 1998
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APPENDIX C

PARTICIPANT LIST
COMMUNITY-BASED IEC STRATEGY DEVELOPMENT WORKSHOP
8-10 JULY 1998
WEBUYE, KENYA

APPENDIX C
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Community-based IEC STRATEGY DEVELOPMENT WORKSHOP
8-10 JULY 1998
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APPENDIX D

PROPOSED OBJECTIVES
TECHNICAL MEETING
6-7 July 1998

APPENDIX D

PROPOSED OBJECTIVES
TECHNICAL MEETING
6-7 July 1998

- Review the national malaria policy and the BDI malaria prevention and management interventions that will be promoted on the project

- Review the findings of research that has been recently completed in Bungoma District and identify knowledge, attitude and practice (KAP) gaps which may exist among health workers, members of the public and structural barriers to optimal care

- Brainstorm ways and means of filling the gaps identified, including discussion of possible audiences, messages and structures

- Make technical recommendations to be considered during the strategy development workshop

APPENDIX E

PROPOSED OBJECTIVES
COMMUNITY-BASED STRATEGY DEVELOPMENT WORKSHOP
8-10 July 1998

APPENDIX E

PROPOSED OBJECTIVES
Community-based STRATEGY DEVELOPMENT WORKSHOP
8-10 July 1998

- Review the BDI Project, the National Malaria Policy and the main issues/ recommendations of the technical meeting

- Develop an IEC and community-based strategy for achieving the BDI objectives

  a identify key behaviours to change
  b identify areas to focus on and possible messages
  c identify 1) key target groups to be reached by the project and media and 2) educational materials to be developed
  d brainstorm possible activities
  e identify community partners for implementing the strategy
  f identify possible indicators and information needed for monitoring and evaluation

- Develop an action plan - to operationalise strategies and activities developed

- Provide up-to-date technical information on effective treatment and prevention measures for malaria

APPENDIX F

TIMETABLE

BDI TECHNICAL MEETING
WEBUYE, KENYA
JULY 6-7, 1998

APPENDIX F
TIMETABLE

BDI TECHNICAL MEETING
WEBUYE, KENYA
JULY 6-7, 1998

MONDAY JULY 6, 1998	TUESDAY JULY 7, 1998
Opening Introductions Workshop times Workshop process Expectations and objectives Timetable The BDI project National malaria policy Assessment and research findings - Household survey - Formative research - BDI assessment - IEC assessment Key problems to address	Problem analysis and selection, target groups Channel analysis and selection Technical recommendations Workshop two * Content * Strategy framework
Mood metre	Mood metre

TIMETABLE

Community-based STRATEGY DEVELOPMENT WORKSHOP
8-10 JULY 1998
WEBUYE, KENYA

WEDNESDAY JULY 8	THURSDAY JULY 9	FRIDAY JULY 10
	Feedback committee report	Feedback committee report
Opening Introductions Workshop times Workshop process Expectations Objectives/ timetable Feedback committee The BDI project National malaria policy Assessment and research findings - Household survey - Formative research - BDI assessment - IEC assessment Key problems	Behaviours to promote Target groups Objectives Channels analysis Partnership analysis Strategy framework Strategy development	Strategy development continued Plan of action Evaluation
Mood metre	Mood metre	Mood metre

APPENDIX G

FACILITATION NOTES
TECHNICAL WORKSHOP

APPENDIX G

FACILITATION NOTES
TECHNICAL WORKSHOP

MONDAY AM

WELCOME/INTRODUCTORY REMARKS
MOH, USAID, AMREF

1 INTRODUCTION (Dondi)

2 WORKSHOP TIMES (Dondi)

3 WORKSHOP PROCESS (Dondi)
Presentations (minimal)
Plenary discussions
Card collection
Group discussion
Typing and distribution of work completed
Continuous and end evaluation
- Mood metre
- Yellow card
- Final evaluation

4 EXPECTATIONS AND OBJECTIVES (Nancy)
Ask everyone to write what they would like to get from this meeting, present objectives and timetable, compare with expectations, modify programme as needed
Card collection (May be typed later and distributed)
Objectives & timetable

5 APPOINTMENT OF FEEDBACK COMMITTEE MEMBERS (Nancy)

MONDAY AFTER TEA

6 THE BDI PROJECT (MOH/Ngugi) (Nancy)
Presentation
Question/answer/note taking
Type and distribute notes taken additional to handout

7 KENYA NATIONAL MALARIA POLICY (Malaria control Unit) (Dondi)
Presentation
Question/answer/note taking
Type and distribute notes

MONDAY AFTER LUNCH

8 ASSESSMENT AND RESEARCH FINDINGS (Nancy)
Emphasize treatment/careseeking behavior what we have now is good formative data on treatment, caretaker behavior - more on prevention and pregnancy to come
Tasks during meeting priorities, sequence - what health workers do is reinforced in the community, what people hear in church is reinforced by what children learn in schools etc
Presentation
- Do any of the findings surprise you?
- Any key findings left out to add?

Participants/facilitators take note of key problems and issues

9 KEY PROBLEMS AND ISSUES (Dondi)(Group work)
* On cards, develop a list of issues and problems to address, divided into appropriate categories (Different colours for different categories)

HOUSEHOLD

HEALTH FACILITY

COMMUNITY

OTHERS

* Prioritise & select problems to address

TUESDAY AM

10 PROBLEM ANALYSIS (Nancy) Define problems as those things which people do which impact on malaria morbidity and mortality Knowledge and attitudes are important only as they relate to specific practices

PROBLEM/ MANIFESTATIONS	BEHAVIOUR TO PROMOTE	BARRIERS TO CORRECT BEHAVIOUR	FACTORS ENCOURAGING CORRECT BEHAVIOUR

Note Target groups to be discussed in detail in Workshop Two

TUESDAY AFTER TEA

11 CHANNELS ANALYSIS (Dondi)(MOVED TO WORKSHOP TWO)

- List available channels (transparency from IEC assessment + additions from participants)
- Select promising channels
- Analyze channels

CHANNEL	OPPORTUNITY FOR USE	STRENGTHS	WEAKNESSES
INTERPERSONAL			
GROUP			
MASS			

Note Select priority communication channels to be emphasised in BDI

TUESDAY AFTER LUNCH

12 TECHNICAL RECOMMENDATIONS (Dondi)

BEHAVIOURS TO PROMOTE

ACTION/BEHAVIOURS TO PROMOTE	LEVEL OF INTERVENTION		
	HOUSEHOLD	HEALTH FACILITY	COMMUNITY
PREVENTION			
HOME MANAGEMENT			
TREATMENT			
COMMUNITY PARTICIPATION			

13 WORKSHOP TWO (Dondi)

- Content (present draft timetable for discussion)
- Strategy framework (Present draft developed by facilitators for discussion)

Strategy framework
GOAL TO REDUCE MORTALITY AND MORBIDITY FROM MALARIA IN CHILDREN UNDER 5 IN BUNGOMA DISTRICT

Note relate to BDI objectives, source of strategy objectives come from technical recommendations table

Objectives in categories Prevention, Home Management, Treatment, Community Participation

STRATEGY	ACTIVITY	TARGET GROUP(S)	CHANNELS	PARTNERS	MATERIALS	INDICATORS OF PROGRESS

Example to improve interaction between mothers (with child with malaria) and health workers and ensure that mothers are able to correctly treat at home, return at the appropriate time (take specific behaviours as specified in technical recommendations table)

Note Indicators of progress are of two kind process which give credit to achievements along the way such as design of materials, pretesting of materials, planning/coordinating meetings, etc and end results such as the percentage of mothers correctly treating the child at home

Note Plan of action not to be developped during workshop, rather DHMT to use strategy to develop plan of action, Nancy and Dondi to work with them on it on Tuesday morning following the workshop

14 Plan of action

ACTIVITY	TIME FRAME	WHO TAKES ACTION	RESOURCES AVAILABLE NEEDED

* Add resources from partners

When editing add resources available from the project

FACILITATION NOTES

COMMUNITY-BASED STRATEGY DEVELOPMENT WORKSHOP

(WORKSHOP TWO)

1 INTRODUCTIONS (Workshop times, process (Dondi)
Participants pair, interview each other and introduce one another

2 EXPECTATIONS (Objectives, timetable, Feedback committee) (Nancy)

3 THE BDI PROJECT (MOH/DHMT)(Nancy)
Presentation and questions

4 NATIONAL MALARIA POLICY (MOH/DHMT)(Nancy)
Presentation and questions

5 ASSESSMENT AND RESEARCH FINDINGS (Sammy)(Dondi)
Presentation Questions/answer

6 KEY PROBLEMS (Dondi)
Distribute research finding summaries and questions identified by the technical committee
Group discussion to identify problems to focus on
Plenary discuss to arrive at the problems to address

7 BEHAVIOURS TO PROMOTE (Nancy)

Hand out the following developed during the Technical Meeting

PROBLEM/ MANIFESTATION	BEHAVIOUR TO PROMOTE	BARRIERS TO BEHAVIOUR	FACTORS ENCOURAGING CORRECT BEHAVIOUR

Ask groups to revise this in view of the research findings

8 TARGET GROUPS (Nancy)

Definitions primary target group, those persons who need to change the behavior or practice, secondary target group, those persons who influence the primary target group, either helping or hindering the appropriate behaviour

PLENARY Based on the problem analysis tables, each person writes a target group on a card and places it on the board as either primary or secondary groups During the discussion, groups are allocated and explanations of why a group is either primary or secondary (refering to problem analysis) and explaining how a particular group can be primary for one action and secondary for another Example fathers/men are a secondary group when the primary group is mothers and the fathers encourage the mother to take the child to the health center Fathers/men may be the primary group when the intervention is trying to convince them to buy mosquito nets and allow women and children to sleep inside them

Groups select the key target groups the BDI project will concentrate on

9 OBJECTIVES (Nancy)

General objectives Out of these, SMART objectives will be developed by the DHMT during planning "The objectives of the strategy are to

Objectives are taken from the second column of the problem analysis, that is to promote the correct behaviours identified for each problem statement

10 PARTNERSHIP ANALYSIS (Dondi)

Development communication model

- Advocacy
- Social mobilization
- Programme communication

Advocacy

- Who holds the key to programme acceptance in the community
- Who are other influential people?

Social Mobilization

- Which agency or individual is interested in malaria?
- What facilities/networks/staff/experience can they bring to the project?
- What influence do they have with the authorities and target groups?

Programme communication

- What network does the partner use to disseminate information?
- What audience categories do the channels reach?
- Are those also the audience categories BDI wishes to reach?

11 STRATEGY FRAMEWORK (Nancy)

Present the draft generated during the Technical Meeting and have it discussed/amended

12 STRATEGY DEVELOPMENT (Dondi/Nancy)

Group work/plenary

13 **PLAN OF ACTION/NEXT STEPS** (Dondı)

14 **EVALUATION**

15 **CLOSING**

APPENDIX H

TECHNICAL MEETING EVALUATION

APPENDIX H
TECHNICAL MEETING
EVALUATION

	High RATING				Low	
	5	4	3	2	1	Average Score
Objective 1 Review of national policy/BDI project	3	17	2			4
Objective 2 Review research, identify KAP gaps	4	11	6	1		3 8
Objective 3 Brainstorm ways of filling gaps	8	9	5			4 1
Objective 4 Make technical recommendations	9	11	1			4 2
Facilitation	6	13	1	1		4 1
Venue	3	14	4	1		3 9
Timekeeping	4	13	4	1		3 9
Usefulness of workshop	13	8				4 6
Feasibility of technical recommendations	5	14	3			4 1

Please comment on the usefulness or otherwise of this workshop as a way of reaching consensus on the technical recommendations

- I was happy at the open mindedness of the facilitators
- This workshop was appropriate and follow-up should be put into consideration
- It is useful though as a starter in the program-needed more time to go through the program
- The forum was very useful, though the technical recommendations may require further review by a small team
- very participatory
- Would have been useful to allow more discussion of controversial issues when they came up instead of deferring them
- AIDS in terms of framework were a most useful methodology-helping to keep discussions focussed
- The workshop has been quite useful and when the deliberations are taken seriously, would go a long way in helping the people of Bungoma and Kenya as a whole
- A good chance to let everyone express their views, hear views on policy and technical information and role recommendations

- The workshop was quite useful in reaching consensus on technical recommendations It is my sincere hope that these recommendations will be turned into a reality
- The workshop has been useful in identifying problems and to warrant workable technical recommendations Well done
- The workshop was useful in that it came out with proper simple technical recommendations that are workable at each level
- Group work on day 1 was confusing to the participants and seemed to have slowed some of the momentum Second day workshop ran more smoothly, was much more participatory and tasks were clearer By the time we reached technical input, there was broad consensus already built
- The proceedings will go a long way in reaching the technical recommendations that will be useful for future implementation on the planning of future activities
- It is a good form to collect varied opinions
- Participants able to make feasible recommendations
- Facilitators did not adequately conduct objective 2 and 3 Many people did not understand and this was evident during group work
- Very useful and with perfect goal but should include all age groups
- It will meet the Pt's (mother and child) demand and enhance treatment and recovery
- The workshop was useful and everybody participated, the final draft of recommendations should be shown to the participants
- The workshop will be able to highlight the reality on the ground

Any other comments (please use the back of this sheet) Thank you!

- More time should have been given to the comments/group work The groups were too rushed
- Great team, great job
- Identify the potential of local resources for maximum utilization
- Should have taken a little longer time for participants to understand better
- Kudos to the organizers and facilitators for putting together this workshop
- The choice of participants and facilitators was very well varied There were very healthy discussions
- We expected major key players eg malaria control program to have attended personally
- On the first day, facilitation was not ready for seminar
- Time tables (for seminar) should be prepared by facilitators
- The malaria control program should be more actively involved in this study of BDI to have a national outlook Otherwise good

APPENDIX I

COMMUNITY-BASED STRATEGY DEVELOPMENT WORKSHOP FINAL EVALUATION

APPENDIX I
COMMUNITY-BASED STRATEGY DEVELOPMENT WORKSHOP
FINAL EVALUATION

	High rating				Low	Average
	5	4	3	2	1	
Objective 1 Review BDI project+tech recommend	8	18	5			4 1
Objective 2 Dev IEC strategy	10	14	4	2		4 1
Objective 3 Dev programme of activities	8	13	7			4
Objective 4 Prov info on malaria	12	12	4	2		4 1
Facilitation	10	16	6			4 1
Venue	8	12	12	1		3 8
Timekeeping	7	18	5	3		4 3
Usefulness of workshop	23	9	1			4 7
How implementable are the strategies/activities developed	5	14	12			3 8
How well were your expectations met	8	15	7	1		4

Which sessions were most useful/informative for you in your work?
- IEC Strategy (target groups, objectives, channels) (17)
- information on malaria (8)
- all (5)
- problem analysis(2)
- policy, standards/guidelines on malaria treatment (3)
- results on BDI research, review BDI Project (2)
- objective development (2)
- group presentation of the strategic steps development - goal -objectives, strategy, activities, The step to IEC planning was very good (2)
- training and sensitizing CHWs
- technical recommendations (2)
- Information on AMREF
- Group discussions, work (3)

Which sessions were the least useful/informative for you in your work?
- All were useful/none (15)
- Introductions (3)

- materials
- a bit of lack of clarity about what exactly some of the building blocks were - eg channels
- research findings
- indicators
- Anopheles mosquito transmitting is very confusing and may make IEC interventions not very clear
- group work sessions
- BDI programme implementation (I work from Nairobi)

Please comment on the usefulness or otherwise of this workshop as a way of developing a community-based malaria management strategy

- very useful, important (10)
- There was great transition from research to plans and all -- participants kept referring back to what we know - very good!
- It should involve many key players -- Government Depts can give in the inputs
- The workshop has been very useful If the strategies arrived at will be used, then the new approach will be acceptable by the communities as long as the communities will be involved initially in the planning up to the end
- The IEC strategy process was well articulated and can be applicable
- A good approach but we missed the MCDC members who often reflect the view of the community
- The workshop is very useful as a lot has been revealed that will be put together as blocks or units to help realise the BDI project
- The workshop has been useful in that it has come out with simple workable advise that can be implemented in the communities but the control measures and preventive measures should be reconsidered for the good of total coverage
- Further extension of the Ministry of Health workers (nurses) to village level
- At least all sectors/cadres were involved and the messages will spread faster
- If fully implemented and the community understands the concept of the programme then the incidence of malaria cases in Bungoma will go down
- was quite useful for my understanding of BDI
- The workshop brought together various partners to discuss IEC, potential partners involved (2)
- especially that community members and non-GOK providers were included
- The workshop was well organised and informative especially in finding out the route causes of malaria in the community The knowledge on which mosquito gives malaria was very useful
- It was a very useful workshop, many more should be done to develop strong IEC nationally on malaria management
- Bungoma a malaria zone with good health facilities compared to other rural areas of Kenya, with active health workers should be able to implement successfully the programme
- It is feasible and can be adopted easily

- partnership analysis
- A very important participatory method of involving all stakeholders in planning
- If the recommendations can be taken and really involve the community and the already established channels in the community - particularly these that can be reached for accountability This is a very good community-based strategy
- The workshop when it finally develop the IEC materials and they become ready will assist the communities quite a lot in the malaria treatment
- Information flow and treatment to be put in place will quickly be enacted upon

What difficulties (if any) do you foresee in implementing the strategies and activities developed during this workshop?

- I don't foresee difficulties that may arise or hinder the development of the workshop unity that is the key to success, none except unforseen (4)
- BDI should go to the local community first before implementing work Le t there be community involvement first then participation
- Commitment on part of all staff
- If the communities will not be involved in the studies going to take place soon
- mobilising the community, getting the community to participate fully (2)
- Time to get all the factors in place is a bit too far
- The community unless supported to realize their weakness and see their own problem from the time go should be supported to stand on their feet Active community participation
- Resources, funding "I am surprised at the energies put on research and workshops, but no financial commitment "Transport and subsistence for field staff (6)
- The idea of voluntarism
- The IEC officers both from local and BASICS etc should also avail themselves during the October planning workshop otherwise, there will be an element of some problems
- Need to strengthen/emphasize the role of the national level
- Agreement between partners
- commitment on the part of partners
- Willingness on the part of caretakers to adopt to the new changes
- The SP drugs for the treatment of malaria will take quite sometime to be acceptable in the communities given the cost element and more so the slow acting mechanism of the drug
- crowding of activities
- lack of incentives for volunteers
- cost and availability of both nets and SP drugs
- If the flow of funds delays or not available
- Also if the DHMT have another big project like this
- Quick implementation from the organising body (DHMT)
- difficulties will be in the supervision and dedication of officers
- Things are still high up = ORs still going - hope will reach the end
- plans and activities need to be coordinated and thought through - very diverse
- will need to rethink a bit when the other research is finished

How can you/your organization help in implementing the strategy developed here for achieving the BDI goal and objectives?

- Passing all relevant information achieved during the workshop to all members of our organization (Salvation Army) , disseminating information, Combined efforts from all corners - support in ways to disseminate the information to reach more people (5)
- By working together - will follow later
- Through networking and working in partnership in the trainings
- Will fund
- provide TA (7)
- supervision (2)
- attending the meetings
- implementing the info given/treatment advices
- through our CBHC program implementation in the community
- Training for awareness
- clinical services
- facilitate the use of nets
- As trainer (2)
- Just as before Continue to be in touch with me Keep inviting me to your DHM committee meetings
- I can help in achieving the objectives through 1) public education, 2) counselling 3) community mobilisation
- By making sure that DHMT is given a bigger say in the budgetary proposals and implementation
- By participating in implementation
- Launching the malaria policy very soon
- I will participate as a health worker
- Commitment to the programme by the hospital management team
- check off system availability so that staff can have treated nets
- Acquisition of SP drugs for use by pregnant mothers and MCH clinics and outreach clinics
- commitment by health workers, especially nurses
- policy implementation
- through community-based facilitation-churches, administrators, CBC, CHW etc
- My organization through the already established community-based workers will give advocacy, offer distribution and IEC which they will do during their usual duties
- by formation of district health steering committee to provide forum for all stakeholders to meet, discuss, plan and share experiences
- planning, organising, supervising and implementation at various stages
- maintain donor/USAID commitment
- help in liaison of agencies and partners
- help in tying national level into BDI
- IEC material development
- I am GOK so I have to do the job

Any other comments Thank you!

- The workshop ended well
- The seminar was very good except money per diem was small for the district level as compared to circulars from DPM (Gov't) (4)
- Plan for more workshops
- This is a good workshop - please push the implementation as fast as possible for the benefit of our community before time lapses
- For the Project to be successful, the team need to involve the communities in the surveys
- Thank you for updating us
- Remember to issue certificates of attendance
- I enjoyed the way Nancy made use of the cards in her facilitation and the way she involved participants
- water shortage in some rooms was experienced
- very well attended facilitated and useful workshop
- Workshop not taken with seriousness it deserves - at international level to nyama choma and pocket lifting
- Being at various level - planning activities were difficult forthcoming!
- A lot accomplished in short time - thanks to facilitators for getting it finished well and to participants who did not slack off

APPENDIX J

BDI COMMUNITY BASED IEC STRATEGY

APPENDIX J

BDI COMMUNITY BASED IEC STRATEGY

1 0 BACKGROUND

Malaria is the leading cause of morbidity and mortality in children under 5 in Bungoma District It also contributes to problems in pregnancy for women, (placental malaria and anemia) and often results in low birth weight babies In response to these concerns, the BDI Project was initiated In order to understand the problem in all its aspects and to effectively solve the problem, the BDI Project bases program activities on research Research completed to date includes a household survey, community quality assessment, formative research on health care seeking behavior among caretakers, an IEC assessment Formative research is planned to look at behaviors and beliefs related to ITM and to issues related to taking prophylactic SP during pregnancy

More effective preventive and treatment technologies exist than are currently being used in Bungoma District Hence, IEC has an important role to play in bringing about changes in knowledge and practices which will help people take the necessary measures to prevent malaria, especially in children and pregnant women, and to treat appropriately the illness when it occurs The BDI Project combines both clinical activities (such as the introduction of IMCI) and IEC in order to reach the goal of reduced morbidity and mortality among the most vulnerable populations, pregnant women and children under 5, in Bungoma District

Both medical technical staff and community members came together in a workshop to discuss the issues and reach consensus on the approaches to take in drafting an IEC strategy for the BDI (See Appendix J-1) The document which follows explains that strategy as well as the process used to develop it

2 0 WORKSHOP DESIGN AND PROCESSES

2 1 The workshop was divided into two parts the technical meeting designed to reach consensus on measures to propose in responding to issues identified in the BDI research and a community based IEC strategy development workshop which included a number of community participants in addition to the participants from the technical meeting

2 2 The process included presentations, plenary discussion, card collection (modified VIPP), group discussion and continuous and end evaluations This evaluation consisted in the use of the "Mood Metre", a daily feedback committee, yellow card warnings which could be used when comments were off subject, boring, or taking too long, and final written evaluations Materials covered were typed and made available for use in subsequent discussions

3 0 RESEARCH FINDINGS

This draft strategy is built on four key pieces of research which describe knowledge and practices related to treatment of malaria in children (research is planned which will relate to prevention during pregnancy and ITM) Highlights of that research include findings that

- Malaria is generally recognized, but not seen as serious and some aspects are treated with traditional remedies
- Caretakers (usually mothers) begin treatment quite rapidly when a child is ill, but often with the wrong drug (anti-pyretics, anti-biotics) and almost always with CQ when using anti-malarials
- Many caretakers display "nomadic care seeking" behavior, going to different providers and shops resulting in both over and under dosage of medicines and duplication
- Many caretakers prefer private providers, and most obtain medicines from local shops, chemists and pharmacies

During both the technical meeting and the Strategy Development workshop (July 6-10), research findings were discussed in order to formulate the problems (See Appendix J-2)

4 0 KEY PROBLEM BEHAVIORS

Based on analysis of the data, eight problems were identified These problems were selected on the basis of their impact on mortality and morbidity from malaria in pregnant women and children under 5 The problems identified were

1 Caretakers treat malaria in children incorrectly with the wrong drugs, in wrong dosages
2 Caretakers delay treatment of malaria with anti-malarials
3 Health workers give incorrect treatment of malaria not using the correct drug, and/or duplicating drugs already given at home and/or by other providers
4 Health workers do not interact well with caretakers by not counseling or providing key information such as feeding advice and danger signs
5 Vendors/chemists/pharmacists/shopkeepers sell incorrect malaria drugs in incorrect doses
6 Pregnant women and children do not use bednets
7 Pregnant women do not take SP chemoprophylaxis
8 Communities are not participating adequately in promoting malaria prevention and treatment measures

Each problem was analyzed in terms of its manifestations, correct behaviors to promote, barriers to adopting the recommended behavior, and factors supportive of the healthy behavior Inadequate information on prevention will be completed by research scheduled for the coming months These analyses are included in tables which follow

PROBLEM ANALYSIS

PROBLEM/MANIFESTATION	BEHAVIOR TO PROMOTE	BARRIERS TO CORRECT BEHAVIOR	FACTORS ENCOURAGING CORRECT BEHAVIOR
Caretaker - incorrect treatment - Most don't know that CQ not effective, SP is recommended treatment for malaria, use of analgesics, belief in efficacy of CQ - When using CQ, give less than required dose - inadequate recognition of malaria, don't distinguish malaria fevers from others - prefer inappropriate treatment (injection), prefer private practitioners - fathers have negative attitude-no money for treatment, no importance to childhood illness - CT take fast action but use antipyretics and antibiotics, only half give antimalarials and use CQ	Correct treatment - Right drug SP - Right dosage (one time)	- CT does not know drugs, dosage - have used CQ, perceived efficacy - Fears of SP strong, costly, creates resistance, slow action of SP - availability of SP - not preferred for children - Preference for proven past treatment - Incorrect identification of diseases/signs/symptoms - lack of money - no husband support - poor advice from providers (HW, vendors) - availability of too many drugs	- CT react quickly to fever - React to some (but not all) danger signs - SP long term (child does not get sick again as quickly) - Clear policy guidelines - SP made in Kenya - SP single dose - easy in house, saves time - CT go to HF within 3 days if home treatment fails

PROBLEM/MANIFESTATION	BEHAVIOR TO PROMOTE	BARRIERS TO CORRECT BEHAVIOR	FACTORS ENCOURAGING CORRECT BEHAVIOR
Caretakers delay beginning treatment with antimalarials - nomadic care seeking - use antipyretics but not antimalarials - negative perception of treatment - malaria and fever not taken as serious diseases - religious, traditional beliefs	Early and correct treatment seeking behavior by CT	- 25% of CT don't recognize early warning symptoms - CT start children on antipyretics - confusion between illness and early warning signs - lack of money to purchase drugs/go to a health facility - lack of correct advice from vendors and pharmacists - wrong treatment at health facility - nomadic care seeking behavior	- majority of CT do recognize most signs - drugs are available in communities - CT take immediate remedial action - easy access to health facility - policy support for malaria treatment by CT

PROBLEM/MANIFESTATION	BEHAVIOR TO PROMOTE	BARRIERS TO CORRECT BEHAVIOR	FACTORS ENCOURAGING CORRECT BEHAVIOR
Health workers give incorrect treatment - do not take adequate history so don't understand illness - are impatient, do not see patients as clients	Correct treatment - right drug SP - right dosage one time with paracetomol for fever reduction	- HW lacking update information on effective drugs/correct dosages - inavailability of correct drug (SP) - misdiagnosis of illness - poor attitudes towards patients (lack of motivation) - unprofessionalism [e g private treatment practitioners, economic gains] - referral system not adequately utilized	- available facilities for diagnoses - availability of qualified personnel - existence of referral system - quick to offer alternative - easy accessibility to private facilities (client friendly) - continuous education e g IMCI - supervision
HW not interacting well with CT counseling, feeding advice, key information, when to return not done or not done well - scold women for coming late	Health workers communicate effectively with CT resulting in willingness to come to health facility and compliance with treatment, feeding advice etc	- too much workload - language differences - poor HW perception of CT - lack of communication skills - some negative perception of HW by CT - HW don't know good management procedures	- IMCI training - CT look to HW for advice - some HW have training

PROBLEM/MANIFESTATION	BEHAVIOR TO PROMOTE	BARRIERS TO BEHAVIOR	FACTORS ENCOURAGING CORRECT BEHAVIOR
Vendors/shopkeepers/pharmacists sell incorrect drugs in incorrect doses	- stock and sell proper drugs - sell proper doses that are consistent with the national policy	- lack knowledge about CQ/SP - some not trained/qualified (e g shopkeepers) - lack of supervision - desire for money/greed - lack of incentive to advise - lack of availability of the drug (SP) - drugs are expensive - many drugs are available - misleading adverts	- entrepreneurs are friendly - saves time - availability more guaranteed - convenience - credit facilities - are trusted, informal
Pregnant women not taking chemoprophylaxis	Take two doses SP prophylaxis treatment in second and third trimester	- Mothers don't attend ANC because of distance from health facility - Pregnant mothers dislike negative attitudes of HW - Pregnant mothers come in early pregnancy only if sick - ANC mothers don't know about SP prophylaxix - poor compliance with prophylactic drugs based on previous experience with iron/folic acid tabs	- pregnant mothers do come to ANC however late - SP compliance should be better since single dose taken at health facility - pregnant mothers do seek treatment when sick

PROBLEM/MANIFESTATION	BEHAVIOR TO PROMOTE	BARRIERS TO CORRECT BEHAVIOR	FACTORS ENCOURAGING CORRECT BEHAVIOR
Pregnant mothers and children not using ITM (insecticide treated bednets)	Use of treated bednets and periodic retreatment	- cost - believed to be for rich people - used mostly by men - children do no use beds - type of houses (temporary and multipurpose) - Fears bednets can catch fire, suffocation - chemicals expensive - smells - chemicals not easily available - dipping of nets cumbersome	- know the use of net - available at BI sites - available in shops - people around the BI sites use them in 9-10 villages - dipping of nets done at BI sites

PROBLEM/MANIFESTATION	BEHAVIOR TO PROMOTE	BARRIERS TO CORRECT BEHAVIOR	FACTORS ENCOURAGING CORRECT BEHAVIOR
Community Participation Communities not participating adequately in health promotion - many volunteers trained but abandon work	Active and widespread participation by communities	- felt needs - support/follow-up - "know-it-alls" in the community - incomplete understanding of community participation by HW - negative attitude by HW - low priority to community - incentives lack of/varying - poverty - volunteers - donor role and practices - time - community not involved from beginning of project - religious prejudice - imposed leaders - illiteracy	- some volunteers are working CBD, CHW, TBA - some HW support community participation - GoK and NGOs interested - research available gives community perspectives - participation exists - "Harambee" - paid staff-health workers infrastructure everywhere - ownership where community have planned - community identified leaders - some innovative programs

5 0 TECHNICAL RECOMMENDATIONS

Participants in the technical meeting reached consensus on the technical elements of the behaviors to be promoted in the IEC strategy Data were presented which showed that chloroquine is no longer effective in treatment of malaria in Kenya The new Guidelines specify sulfadoxine + pyrimethamine (SP) For each of the problems analyzed, technical recommendations were formulated These are based on the National Policy Guidelines drafted by the Malaria Control Unit, and due to be launched before October We wanted to be very clear on the exact recommendations to be made For example, when a child has a high fever, is the recommended behavior to be to give SP in the home or to take the child to the health facility? The New Guidelines recommend giving SP treatment in the home so the Group adopted this behavior as its technical recommendation Technical recommendations were drafted for all of the behaviors specifically related to treatment and prevention

TECHNICAL RECOMMENDATIONS

1 TREATMENT

Household	Health Facility
Give sulfadoxine + pyrimethamine for treatment of malaria and paracetamol to bring down the temperature - Common SPs to give are Fansidar and Metakelfin - Common paracetamol to give is Panadol - Tepid sponging - For dosage, see Guidelines pages 33, 34 and 18 - Start treatment as soon as first warning signs appear - Take patient to the clinic immediately when one of the following danger signs appears (not eating, fever lasting more than three days, convulsions, irritable, excessive sleeping, vomiting everything eaten) - Provide supportive treatment (increased fluids, continued feeding, tepid sponging)	All children over two months with a history of fever should be treated with SP - Dosage is on pages 18, 33 and 34 of the Guidelines - Patients with fever classification should be referred to the hospital - Patients allergic to sulfur should be treated with amodiaquine - Take SP with plenty of water - Give information where to get SP

2 HEALTH WORKER INTERACTION WITH CARETAKERS

- Ask about symptoms, treatment before coming to the health facility, duration of illness, previous use and allergy
- Explain the following to caretaker diagnosis, medication and how to take medicine
- Inform the mother about SP and/or why the change to SP
- Encourage caretaker to give the full dose even if symptoms cease
- Tell caretakers when to return to the health facility if fever persists, or any of the danger signs or side effects appear (rash in the mouth, eyes, etc)
- Tell about supportive treatment (fluids, feeding and tepid sponging)

3 PHARMACISTS AND VENDORS SELL INCORRECT DRUGS IN INCORRECT DOSAGE

Technicians and Pharmacists	Pharmacy Attendants	Vendors (Shopkeepers/Kiosk/Mobile)
- Disseminate MOH Guidelines and IMCI protocol - Drug labeling - Training for pharmacy attendants - Counsel clients - Employ at least one technical person per pharmacy - Not allow untrained staff to dispense part-1 (drugs) - Do not change clinician's prescription (drugs) - Do not treat patients - Do not sell expired drugs - Take SP with plenty of water	- Acquaint self with malaria treatment - Take history of previous treatment - If Fansidar not previously given and child not allergic, give Fansidar - If in doubt, refer to the pharmacist or health facility - Label drugs well (if not already labeled) - Do not sell expired drugs	- Acquaint with proper treatment - Know effective ("good") malaria drugs and antipyretics to sell - Take history of previous treatment before selling - If Fansidar not previously given and child not allergic, give Fansidar - Do not sell expired drugs

4 CHILDREN AND PREGNANT MOTHERS DO NOT USE BEDNETS

- All children and pregnant mothers should sleep under bednets
- Bednets should be re-impregnated according to guidelines (AMREF Research)
- Bednets should be used during peak biting time (22 00 - 05 00)
- Bednets should be used all year long

5 MALARIA CHEMOPROPHYLAXIX FOR PREGNANT WOMEN

Pregnant Women	Others	Health Workers
- Attend ANC monthly as soon as you know that you are pregnant - Ensure you get SP chemoprophylaxis doses at the beginning of the second and third trimesters at the health facility	- Train TBAs and other health promoters to refer mothers to health facilities for SP chemoprophylaxis	- Revise ANC card to include SP for pregnant mothers (alongside TT) - Acquaint health workers with malaria treatment in general and malaria chemophrphylaxis in particular This will include dosage, reaction to SP and what to do - Ensure all pregnant mothers get chemoprophylaxis in the second and third trimesters

6 0 THE STRATEGY

Analysis of research data, determination of problem behaviors to focus on and consensus on technical recommendations set the stage for strategy development This included reaching agreement on the following

- Project Goal
- Target Groups
- IEC Objectives
- Channels of communication
- Partners
- Strategies
- Activities
- IEC and Training Materials
- Progress Indicators

6 1 Project Goal To reduce the morbidity and mortality from malaria among children under age 5 and pregnant women through improved management of patients with fever and anemia, improved capability of mothers and other caretakers to manage fever and anemia in children under five, improved prevention and management of malaria in pregnancy, increased household use of ITM, and effective collection and use of information for planning, monitoring and evaluation of project activities

6 2 Target Groups

Target groups were analyzed on the basis of their role in changing or modifying the eight problem behaviors Primary and secondary targets were identified

Discussions showed that whether a particular group was in the primary or secondary target group depended on whether the persons displayed the problem behavior or influenced the primary group For example, when promoting correct treatment of malaria in children, caretakers become the primary target group and health workers the secondary target group In promoting correct treatment at health facilities, health workers become the primary group Community leaders become a secondary group in promotion of correct treatment of malaria among caretakers, while they may be a primary target when promotion of community participation is the issue After discussions, it was resolved to categorize identified key target groups as below

Primary Caretakers, mothers, fathers, pregnant mothers, shopkeepers, pharmaceutical assistants, health workers, community leaders

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Secondary Opinion leaders, provincial administration, fathers, religious leaders, pharmacists, TBA, community health workers, CBD agents, growth monitoring agents, teachers, schoolchildren

6 3 IEC Objectives

It was recommended that BDI develop "SMART" IEC objectives with clear progress indicators to facilitate monitoring, evaluation and program development generally [SMART stands for specific, measurable, attainable, reasonable and timebound]

It was, however, felt that aiming to develop such a level of objectives within the limited time of the workshop was unrealistic The workshop therefore settled for more general objectives which would be reviewed at a later date by the DHMT and turned into "SMART" objectives Drawn from the problem analyses tables, the following IEC objectives for the period 1999-2002 were developed

1) To promote among caretakers the correct treatment of malaria in children under 5 using SP in the correct dosage
2) To promote early and correct malaria treatment seeking behavior among caretakers looking after children under 5 years
3) To promote among health workers the correct treatment of malaria in children under 5 using SP in the correct dosage
4) To promote effective communication between health workers and caretakers who bring children under 5 with malaria to the health facility for treatment,
5) To promote the sale of the correct drugs in correct doses among vendors, shopkeepers, chemists, pharmacists,
6) To promote the use of insecticide treated bednets among pregnant women and children under 5,
7) To promote among pregnant mothers the taking of 2 doses of SP prophylaxis treatment during the second and third trimester
8) To promote active and broad participation by the community in order to achieve BDI objectives

6 4 Channels of Communication

During the workshop, the channels were classified in mass, group and one on one settings to ensure that each setting is given adequate attention The channels were then evaluated and the following table prepared to guide the planning process

CHANNELS

Mass	Group	IPC
- *Barazas* - Church congregations - Meeting at markets - Funerals - Drug outlets (advice materials) - Schools and colleges - Shows - Mass mailing	- Micro teaching mothers union and equivalent (health talks) - Women's groups - Youth groups - Self-help groups - Men's groups - Church groups - Village health committees - Seminars/workshops - Water points - *Posho* mills - Schools and colleges - Bars - TBAs - Factories	- Home visits - Counseling in health facilities - Pastoral counseling - Marriage ceremonies and drug outlets (counseling) - *Posho* mills - Schools and colleges - Bars - TBAs/traditional healers - Saloons - Hotels

Each of the channels was analyzed according to opportunity for use, its strengths and weaknesses (See Appendix J-2, page 33)

6 5 Partners

The workshop identified partners on the basis of their potential to play advocacy, social mobilization and program communication roles It was recognized that many agencies play more than one role and this was reflected in the analysis The partners rated included government departments, churches and other religious organizations, elected officials, the local governments, women's organizations, Maendeleo ya Wanawake Organization, AMREF, private health facilities, schools, factories and other major employers

6 6 Key Strategies

Five key IEC strategies were identified for the promotion of malaria treatment and prevention These are use of

- Mass media
- Mass meetings
- Existing Groups
- One on One communication opportunities
- Training for skills and capacity building

6 6 1 Mass Media

Mass media was identified as an important means for announcing the BDI IEC initiative creating general awareness, legitimizing the initiative and tying together the different components Radio and newspapers will be used to disseminate information on

- the BDI Project
- IEC launching activities
- purpose and benefits of the IEC initiative
- malaria treatment and prevention
- notable research findings

Other roles of the mass media will be to counteract misleading adverts, to promote the buying of correct drugs from approved shops and to create demand for SP

6 6 2 Mass meetings

Mass meetings will be the key strategy for introducing improved malaria treatment and prevention in the community Barazas, church congregations, funerals, harambee meetings and other gatherings will be used to announce and highlight the IEC initiative This will include creating awareness about the need to inform health workers about all treatments initiated in the home, promoting the stocking and sale of SP in shops (open air shows), when initiated, informing about the bednet program, generating interest in the BDI project in the community for awareness and encouraging participation Health workers, the provincial administration, religious and other community leaders will be identified and given appropriate training and educational aids that will help them play a lead role in this strategy Mass meetings provide an excellent opportunity for reaching the male population especially fathers and community leaders

6 6 3 Existing Groups

Group IEC settings will provide opportunities to discuss and internalize messages from mass and other sources They will promote peer interaction which will lead to more in-depth understanding of messages and increased support for the behavior change process Efforts will be made to integrate malaria education in ongoing activities of groups such as religious groups, women's organizations, men's groups, Harambee and cooperative groups

Organized group activities such as groups of caretakers at health facilities learning about SP and correct dose, youth groups, schools, volunteers as secondary target groups to influence/support caretakers, keeping savings (to be ready for expenses when child becomes ill), with women's groups about correct treatment, buying SP from trained shopkeepers, for promotion of bednets, for demand creation about prophylactic SP for pregnant women, for stimulating community participation in planning, problem solving

6 6 4 One on One settings

One on One settings will provide opportunities for more personalized IEC, persuasion, and addressing issues that individuals in target groups may be unwilling to discuss in groups or public settings One on One opportunities to be used would include home visits, counseling between caretakers and health workers, advising/counseling between caretakers and vendors/shopkeepers etc, advising/counseling between caretakers and trained volunteers, and mother to mother, neighbor to neighbor, man to man For educating in the home on correct treatment, importance of providing information about treatment given before going to the health facility, counseling on feeding advice, return visits, danger signs, problem solving related to hanging bednets etc

6 6 5 Training

Key categories expected to play an important role in bringing about improved prevention and treatment of malaria will be identified and given appropriate training to equip them for their roles Cadres to be trained will include the following

A Health workers IMCI, new treatment recommended and national policy, IPC and how to work with caretakers as a team, on-the-job training for both treatment and improved interaction

B Shopkeepers/vendors/ pharmacists to be trained to give correct advice on SP and dosage to caretakers, to be able to tell caretakers the first signs and symptoms and the danger signs of malaria

C Community leaders/opinion leaders to be able to advise and explain correctly treatment for malaria, use of bednets and treatment,

D Caretakers to be able to use bednets correctly, depending on program, to dip or get bednets dipped, to be able to explain child's treatment history clearly to health workers, to be able to recognize warning signs and danger in child's condition

E Community volunteers (CHW, CBD,) to be able to explain correctly treatment for malaria and provide counseling in one to one encounters with caretakers, to be able to demonstrate proper use of bednet and how to treat and retreat

F Teachers, employers groups use and treatment of bednets

F Traditional healers/herbalists/TBA to be able to recognize cases of *lini* and *embaha* as malaria and refer urgently to health facility, to be able to explain correctly treatment for malaria and refer as needed to health facility

6 7 Activities

Activities to support the strategies above are outlined at number 7 0

6 8 Messages

The workshop identified the technical recommendations, problem behaviors and the behaviors to promote This should guide message development The messages developed should however be thoroughly tested with the target groups They must be pretested with the target groups to evaluate appropriateness, whether the action is doable or not, suitability of language

6 9 IEC Materials

It is proposed to develop the following IEC and training materials to support the initiative The following IEC and training materials were recommended Materials will be identified for design and development during the more detailed planning required for specific activities

Materials for Training	IEC Materials
- Policy guidelines for all health facilities - Job aids (for SP training) - Poster on treatment doses of SP and in pregnancy for health workers - Checklists, supervision protocol to assure quality of care at health facility - Poster, leaflet on health worker/caretaker working together - giving history, welcoming the client - Written script (sales pitch) for PA/sales agents - Dosing chart, labeling guide or labels - New ANC cards with indication for SP and TT	- Leaflets and posters promoting SP for community members, caretakers, health workers - Posters on the need to have savings for medicine and transport when a child has malaria - Scripts for radio for demand creation of SP - Posters, leaflets, reminders for bednets use and treatment - Printed *lesos*, caps, T-shirts, calendars for specific activities (as identifiers for trained volunteers, shopkeepers, caretakers, health workers for example), also as triggers to caretakers to initiate a correct behavior

6 6 10 Monitoring, Evaluation and Documentation

Overall indicators are defined as part of the BDI (e g , proportion of children treated correctly with SP,) IEC strategy indicators will need to be developed specific to the activities and address the planning and implementation stages as well as outcomes The household survey exists as a baseline

At end of project, another household survey should be done, and more qualitative research will identify behavior changes which will have taken place Materials development should also be carefully documented particularly design, pretesting, revisions, production and distribution, proportion of target group reached

Based on the activities discussed during the workshop, a number of indicators were proposed, but they will need to be selected and refined depending on the eventual activities to be implemented

7 0 CALENDAR OF ACTIVITIES

This calendar provides the basis for discussions between the DHMT and all partners to finalize the strategy, select activities and assign responsibilities for carrying them out

Activities	Time Frame	Action
Research and Planning		
- Annual BDI planning mtg	October, 1998	
- Drug outlets assessment	July/August 1998	
- ITM formative	August/September 1998	
- Lab microscopy	September 1998	
- Assessment of NGO facilities	September/October 1998	
- Malaria in pregnancy formative	November 1998	
- Data analysis and completion of IEC strategy for prevention	January 1999	
- Planning/Strategy development for community participation	November 1998	
Materials Development		
- planning identification of messages for target groups, testing	July/August 1998	
- deciding on materials to produce	August 1998	
- design and pretesting	September/October/Nov '98	
- production	January/Feb 1999	
- distribution	March/April 1999	

Training - Planning dev training designs, prepare materials - pretest for each target group, revise - Train health workers - Train shopkeepers/vendors - Train community leaders - Train community volunteers - Train TBA/traditional healers	November/December/Jan/ Feb/March	
Mass Media - Put up signs, posters, adverts promoting SP - Broadcast demand creation for SP messages - radio to encourage caretakers to buy drugs from approved shops - newspapers to promote bednets (features and coverage of launching)	March 1999	
Mass Meetings - Disseminate information about treatment - Disseminate information about the need for health workers to know about all treatment initiated at home - Disseminate information at open air show about stocking and sale of SP - Disseminate information about bednet program - Discuss BDI activities to generate interest/participation		

Group - microteaching at health facilities for Caretakers on treatment and for pregnant mothers on SP prophylaxis - Facilitate discussions with women's groups about correct treatment for children, SP prophylaxis for pregnant mothers - Facilitate discussions with community groups for encouraging participation and problem solving		
One on One communication opportunities - home visits - counseling between caretakers and HW - Caretakers and vendors - Caretakers and trained volunteers - peer education (mother to mother, neighbor to neighbor, man to man		

8 0 CONSULTANTS' RECOMMENDATIONS

8 1 The DHMT should take early steps to finalize this strategy document and develop a definite time frame for implementing the various activities

8 2 Materials development related to treatment of malaria can and should begin as soon as possible in 1998 The process requires design, technical review, pretesting, revision, testing again, production -- all before the activities requiring them can begin This will take 6 or more months and will delay project implementation if started in 1999

8 3 A workshop for community leaders to look at various models of community participation, identify innovative/creative ways for involving communities, and to make plans to initiate activities is needed It may be useful to precede the workshop with some highly specific, targeted qualitative research to identify the factors which promote and hinder community participation in Bungoma District

8 4 Now that the strategy document is ready and IEC activities that need to be implemented are known, BASICS should take an early opportunity to indicate the activities it will support A planning meeting with all partners to discuss budgets, roles and responsibilities is needed, perhaps to be convened by USAID

8 5 The DHMT and facilitating consultants should obtain information from the training of shopkeepers taking place in the Coast Province, acquaint themselves with it and share the information with all partners

8 6 Steps should be taken to facilitate establishment of community level committees to promote community involvement in planning and implementation of malaria management activities

8 7 In addition to involving the population, community level committees should be supported to provide ongoing feedback about activities implemented on the ground

8 8 A process such as the one used in the development of this strategy should be used to generate bednet and malaria prophylaxis in pregnancy strategies once the formative research is available If participants from the present workshop are involved, the process could be completed in a one or two day working session

8 9 Consider creating a mechanism for sharing ideas and information with communities and partners about BDI activities Mechanisms such as a newsletter, a weekly radio program, circular notices would be useful

8 10 As far as possible, messages should be developed to meet the needs of specific target groups and segmented audiences within them Messages and materials for use by church groups could build on Biblical messages while messages for use through factories could be based on the increased productivity which results when the worker's mind is at peace because he has protected his wife and baby with a bednet

APPENDICES

APPENDICES

APPENDIX J-1
PARTICIPANT LIST
COMMUNITY-BASED IEC STRATEGY DEVELOPMENT WORKSHOP
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APPENDIX J-2

SUMMARY OF KEY FINDINGS FROM THE HOUSEHOLD SURVEY, BDI ASSESSMENT RESULTS REVIEW, FORMATIVE RESEARCH AND IEC ASSESSMENT

HOUSEHOLD SURVEY was conducted from 18-31 July 1996 in Bungoma District The study population included children under age 5 and their primary female caretakers A cluster sample was used, and 670 interviews were completed

BDI ASSESSMENT RESULTS REVIEW/QUALITATIVE COMMUNITY RESEARCH

was conducted in July 1996 in 7 villages, one per division in Bungoma District Research objectives included learning about caretakers/mothers' use of terms for fevers, symptoms and causes, their care seeking process, different treatments used and perception of effectiveness, their attitudes toward and experiences with health workers and health centers, preventive measures known and used for children and pregnant women, availability of treatments and preventive measures, potential for increasing availability of treatment and prevention, and perception of seasonality of fevers and causes Eight researchers were trained and used key informant individual interviews (33), individual interviews with mothers of febrile children (29), group interviews(7), mystery client-drug sellers (41), pharmacy/store checks (48)

FORMATIVE RESEARCH was conducted in February-March, 1998 in the catchment areas of eight health facilities in Bungoma District Methods included focus groups and illness narratives with mothers/caretakers, health facility interviews with caretakers, interviews with providers both facility and non-facility based

IEC ASSESSMENT was conducted in March-April 1998 in all nine administrative divisions of Bungoma District Data was collected qualitatively through a review of records and interviews using a discussion guide 161 health workers and members of the public were interviewed

Area of Interest	Household Survey	BDI Assessment Review	Formative Research	IEC Assessment
RECOGNITION OF SIGNS/SYMPTOMS, LOCAL TERMS FOR MALARIA		*Kumerengo* generically used for fever, malaria, cerebral malaria very hot head with cold body and runny nose 17 terms, most associated with fever, some diarrhea, chills, fast breathing, pain/weakness in joints, convulsions Seasonality *mufula* (rainy) high perceived + actual malaria, *musirumbi* (short rains), less perceived malaria, *musimiyu* (dry) little perceived malaria	*Kumerengo* + malaria widely used, *lini* not classified as malaria (it is) and *embaha* hot body, cold feet w/diarrhea, treated w/herbs but is malaria	

Area of interest	Household survey	BDI Assessment Review	Formative Research	IEC Assessment
MANAGEMENT/TREATMENT OF CHILDREN UNDER 5 YEARS WITH A FEBRILE ILLNESS	Febrile illness in last 2 weeks N=312 68% thought it was malaria 43% were seen at a health fac Approx two-thirds were given drugs at home Of those who did not go to a health fac , almost all given drugs at home Of those taken to health fac , <10% taken on day 1, by day 2, about 50%, by day 3 about 80% Drugs given at home (N=305) Antimalarials (with or without antipyretics) 44% Antipyretics only 24% Of mothers who thought child had malaria, about half gave antimalarials, almost always chloroquine Of children treated at home and given chloroquine on the first day (N=98), only 64% received CQ the second day, only 38% the third day, 7% the fourth day	Trigger symptoms lack of appetite, sleeplessness or sleeping too much, crying all the time, very hot body, shivering/convulsions, fast breathing, frequent vomiting, pale, inactive, looks dehydrated Treatment options sponge, give fluids, buy drugs at duka, chemist, give, if symptoms suggest witchcraft, go to herbalist, if don't get better, go to health facility or private clinic Signs of bewitchment swelling, bulging, mental illness, teeth gnashing and diarrhea in kids Barriers lack of money, role of father, religious beliefs, distance, time work, public health workers scolding them, lack of child care, belief that treatment with choloroquine works (reduces fever)	Derived from 97 illness narratives >96% first treat at home with modern drugs about two-thirds perceived the illness to be malaria >50% give antimalarials 30% give only antipyretics most children receive 2-3 different drugs CQ most commonly used, SP considered expensive Of those giving antimalarials, one-third gave correct dose, one third gave underdose, one-third gave overdose tepid sponging taught by providers, used by 10-15% Popular home treatment to give antimalarials with antipyretics and antibiotics which gives good short term response Mothers can get drugs used by health facilities at pharmacy so save time and expense by going directly to a pharmacy rather than health facility Of 97, half taken to health facility, typically if symptoms persist after 1-3 days home treatment	Men have strong voice in how their children get treated when sick and provide bus fare or other costs, chores relating to management of environment

Area of interest	Household survey	BDI Assessment Review	Formative Research	IEC Assessment
MANAGEMENT/TREATMENT OF CHILDREN UNDER 5 YEARS WITH A FEBRILE ILLNESS - CONTINUED			Most providers ask basic questions about symptoms/trtmnts but history taken often inadequate, feeding advice not routinely given, virtually all give medication but importance of giving full dose of CQ not explained, little explanation of SP, no written instructions Adequate staff appears to be problem at private clinics	

Area of interest	Household survey	BDI assessment review	Formative Research	IEC Assessment
SOURCES, AVAILABILITY AND USE OF ANTIMALARIALS IN THE COMMUNITY	Two main sources of home treatment (N=174) are chemist 54% and duka/shop 29% In only 13% was the health fac the closest place to get drugs, duka/shop 44% and chemist 38%, although almost all could reach a site by foot	CQ used most often by mothers, perceived as effective, injections even more effective, though some think they are too strong for child SP used if think child resistant to CQ though many don't know SP and not widely available in shops only pharmacies, seen as expensive, considered effective, some think Fansidar causes resistance to other medicines panadol or aspirin often used with antimalarials	Preference for private clinics CHW no longer have drugs Mothers don't report seeing traditional healers Perceive SP as stronger than CQ, maybe too strong for young children, takes longer to work but child stays longer without malaria after given Appears that there should not be significant barriers to acceptance of SP once health centers recommend it widely and mothers see other mothers using it with good results	

Area of interest	Household survey	BDI ASSESSMENT REVIEW	Formative Research	IEC Assessment
CARETAKER'S KNOWLEDGE OF CAUSE OF MALARIA	63% said mosquitoes 54% said cold 12% did not know 9% Eating new foods 5-6%for each response getting rained on, standing in stagnant water, change in climate 3% said bushes <1% indicated witchcraft			
CARETAKER'S KNOWLEDGE OF PREVENTION AND BEDNETS	35% antimalarials 25% wear warm clothes 23% do not know 17% bednets 11% sprays/coils 9% clear bushes 8% destroy vessels with water 1% burn leaves/dung	anti-breeding, biting clear bush, grass, stagnant water, rubbish, tins, burn cow dung, leaves, *kamarakaru* leaves, *bufwofwo* herbs, *sifofo* leaves, beating mosquito w/hands, coils, Vaseline mos Repellant, sprays, drinking alcohol Low use of bednets, more by people w/regular income, mothers near rivers, living close to BICP, more by men, hanging difficult, not much net dipping Hi awareness, little use Barriers cost, perception of effectiveness		

Area of interest	Household survey	BDI assessment review	Formative Research	IEC Assessment
CORRECT USE OF BEDNETS BY CHILDREN UNDER 5 YEARS OF AGE	Almost all know what a bednet is, in <10% households is it used by a family member or child under age 5 Most were bought at a shop 55% or market/vendor 30%			
ANTENATAL CARE/PREGNANCY	Of those pregnant and giving birth in last 2 years, 86% had 3 or more visits	Women begin visits 3-6 months gestation, 4-5 visits to find baby's position, see weight gain, to get card for birth in hospital Reasons not to go distance, tiredness, no problems, cost of hosp delivery, TBA didn't advise, reaction of HW, modesty, shame Women go to TBA because nearby, no wait, traditional herbs though pay every time Mothers tend to give birth at home Pregnancy special time, special care ok Medications given 2 tetanus, iron/folic acid no reported chemoprophylaxis		

TARGET AUDIENCES AND CHANNELS OF COMMUNICATION		doctor once consulted is most influential, CHW not asked for advice, TBA and CBD only for pregnancy and FP, not for children some husbands will send mother to get money back if child not given injection at health facility	Mothers make their own decisions, sometimes consult with husband, mother or mother-in-law Fathers play small role in caring for sick children Almost all communication regarding treatment is IPC Few mothers have access to mass media, literacy marginal, newspapers expensive, television rare, radio more common but mothers may not have access Most information that mothers have is from talks at health facility Other groups such as women's, church, etc are found in most communities	Good infrastructure with potential to effectively deliver messages from the district to village level facility based paid motivators, community based motivators, provincial administration, church, schools, NGOs, mission and private health facilities Prevalence of radio sets is high Channels of com *barazas* (public meetings), churches, schools, funerals, during mobile clinics, home visits, women and youth meetings Preference for health facilities, *mukasa*, churches, radio and schools Target audiences ANC mothers, patients, people from a specific village

MESSAGES CURRENTLY IN USE				Range of messages too wide and some of questionable value for malaria control and treatment No standardized, generally agreed package of malaria control messages Clearing bushes round homes and draining stagnant water seem to be the most emphasized of all messages
POTENTIAL BARRIERS TO EFFECTIVE IEC				Inadequate supportive supervision from health workers Infrequent community visits by health workers who provide IEC Most community based volunteer motivators have stopped doing health work IEC activities emphasize women, leave out men Poor communication between caretakers and health workers Lack of appropriate educational materials

RECOMMENDATIONS FOR THE STRATEGY		Channels of com people e g HW, pharmacists, DO, *liguru, mukhasa,* religious leaders, groups e g women, men, church, cooperatives etc, places e g *barazas*, church, funerals, drinking places, radio, etc Barrier to bednets is cost explore merry-go-round payment, installment plan, local production, dipping consider dipping curtains, blankets, train CHW to dip, small containers for permethrine Administer chem prophy during antenatal	IEC + overall strategy to address factors such as quality of care and enforcement of prescription regulations MOH agreement on optimal treatment especially caretaker behaviors Work w/pharmacies must be major part of strategy Specific home care guidelines need to be developed and taught to mothers Trg of providers history taking, communication, new drug policy, importance of feeding advice Dev anti-malarial, antibiotic card for non literate caretakers Work w/trad healers for referral of *embaha/lini*	Determine minimum package of effective, actionable malaria messages/intervention s to promote Use channels preferred by most people, e g health facilities, *mukasa,* churches, radio and schools Provide target-oriented IEC training to those doing message dissemination Find solutions to problems of volunterism, com participation and supportive supervision Develop strategies for greater involvement of men in view of their decision taking role in homes

			Mothers should constitute primary target audience for communication, fathers secondary target audience since purchase drugs Counseling mothers SP takes longer than CQ, recover more fully w/SP, not give other meds w/SP IEC strategy based on IPC + others Materials for health talks Use existing community orgs to disseminate info	